General Observations from the Town Hall Meetings

- Of the 171 individuals who filled out the Participant Feedback Sheet, the vast majority of respondents either strongly supported or supported the proposed strategies.

- There was some variation in the level of support for the strategies based on the responses to the Participant Feedback Sheet. The strategy involving the expansion of the 340B Program received the highest level of support where 91 percent either strongly supported or supported it. The strategy involving the implementation of a reinsurance program was the least supported, but 62 percent either strongly supported or supported the recommendation.

- Coverage for mental health and substance abuse services and mental health parity were mentioned relatively often.

- Although there was some mention of other strategies such as large purchasing pools and tax incentives for small businesses, they were not mentioned very often and there did not appear to be strong support for them.

- There was considerable discussion and interest in community health centers and strategies to reduce the cost of medications.

- In rural areas there was considerable concern about the lack of dentists that see Medicaid and uninsured patients.

- There was a general concern that the strategies do not address the rising cost of health care.

- There were several comments related to assuring that preventive services are covered.

- In addition to implementing a disease management program and joining a multi-state purchasing pool to purchase prescription drugs, several people commented about finding other ways to lower Medicaid costs (e.g., expanding home and community-based services for long-term care patients).

- Questions were raised about how to cover undocumented workers.

- It was suggested that the FQHC concept and the 340B medication discounts be expanded to critical access hospitals and rural health clinics. Currently, this is not an option unless a critical access hospital receives disproportionate share reimbursement.

- There were several comments about whether the supply of health professionals is adequate to treat all patients who may need care if insurance coverage expands.

Nebraska Health Insurance Policy Coalition
Omaha Town Hall Meeting
May 9, 2005

Comments from the Audience

1. Why are there only two FQHCs in the area? Is the problem money or not enough funding?

   Response A: The challenge is getting qualified and getting the right numbers and population. Has to be a great deal of political will in the community. Arduous and lengthy grant process which may be too much for small communities. There might me a threat to private practice. There are many regulations that come with government money. Federal grant doesn't cover all costs.

   Response B: Best opportunity might be through existing clinics and creating satellites. The opportunity is there, do it with what you have and not make a new center. Research and studies need to be done to see what exactly is needed. Much easier to create satellite than to start new CHC.

   Response C: The goal is not to blanket the state with FQHCs, satellites and FQHC "look-a-likes" offer opportunities.

2. County governments are not mentioned in the strategies. The county is required to take care of indigent people. There are 1,400 eligible people in Douglas County and 400 are receiving care through the county. This really needs to be a part of your work. Health centers take care of primary care needs, but by the time the patient is seen their condition warrants more specialized care which is not easily found. County programs are 100% property tax funded.

3. FQHCs are meant to be created for places without health facilities. Should increase CHCs in rural or other areas without tax-exempt facilities. Tax exempt facilities should be providing the care. If you look at someone without health insurance, under the laws they have to be treated. Many times someone that does not have health insurance is turned away from the hospital. Need to enforce existing regulations with regard to treating uninsured.

4. There are a lot of adults with chronic conditions that do not qualify for Medicaid. Disease management should be expanded to meet anyone in poverty. I strongly support the disease management strategy.

5. In favor of Strategy 1. Mental health patients are "bounced" in and out of Medicaid. There is a disincentive to get a job because you lose the Medicaid, but jobs are beneficial for people with mental health issues to aid in the healing process. Allow people to work and have insurance. We need to share insurance premiums across agencies.

6. I have problems with many strategies. People with disabilities need specialized care that FQHCs cannot provide. Did not address disabilities of any kind. There are over 200,000 disabled people in the state. Drug programs get into issues of formularies, really expensive drugs and discount programs are not going to cover. Medicare has a 24-month waiting period—people die before getting the care needed or their condition gets worse. Most insurance programs do not offer parity. Mental illnesses are not treated the same way as other illnesses. You really need to evaluate people with disabilities different than the uninsured/low-income population.

7. I agree about issues with mental health parity. Many times kids are not covered by insurance and end up being placed as wards of the state in order to get care. Mental health and substance abuse issues need to be looked at separately.

8. The Nebraska Medicaid prescription program is based off of discount from the average wholesale price (AWP), not the average sales price (ASP). Drug manufactures use average wholesale price to increase their market share. Pharmacies get reimbursed at an average sale price; this could be

"touted" as a source of income for pharmacies. We need to consider access to retail pharmacies in rural areas. I recommend that Medicaid base reimbursement on average sale price and increase dispensing fees paid to pharmacies to ensure access to retail pharmacies. Voice support for reinsurance—great incentive for small employers.

9. I have concerns about Strategy 3. Medicare offers prescription drug discount, but main roadblock is doctors won't take the time to fill out the proper forms.

   Response A: There are programs out there but the general feeling is they are not taken advantage of.

   Response B: The reason they are not being taken advantage of is because physicians are not willing to do the work.

   Response C: Need to allow physicians to do the least amount of paperwork and maybe it would improve usage of discounts.

10. Three questions. The education to consumers is important, but what are the outcomes? What is meant by not replacing private coverage with public coverage (why is that a strategy)? How do you hear the voices of those not at the table?

    Response A: In total there are 21-22 focus groups, household and employer studies plus town hall meetings and we are trying to reach out as much as possible, but it is difficult to include everyone. It might not be a perfect process, but we will see how it works out. Newer refugees come from countries where insurance is provided. They do not understand insurance here and some small employers also do not understand. Need to make some target groups more knowledgeable. Strategies are meant to be in combination with each other. General principle—we are not saying never expand public coverage, we're saying don't <u>replace</u> it.

11. My question deals with money. The federal government has just cut the Medicaid budget and Nebraska is looking at making changes. Since this is a two-year budget will it not be changed until 2007 when legislature meets again?

    Response A: Expanding Medicaid will cost the state money. It is not the trend to allocate more money, but may be willing to do this. Budgets can be changed mid-stream.

12. One thing overlooked was long-term care. There is a role for the state to make long-term care affordable. There is an incentive for private pay patients to "spend down" in order to qualify for Medicaid. The LB 712 prescription drug plan had good possibilities. People who are uninsured and have to go to the hospital, it is ridiculous to charge them the full rate. They should be charged the Medicaid rate.

13. Kids Connection is very cost-effective and we need to keep and expand it. Kids Connection needs to incorporate prenatal strategies. Preconception and pre-pregnancy care is important. Very important to insure mothers and children.

    Response A: IOM came out with the cost of not insuring people. People do not realize how expensive the uninsured are in terms of lost productivity.

14. There is no strategy to promote individual strategy and wellness. Strategy 5 should include funds for things like smoking cessation. Just because a new more expensive drug is on the market who decides what should be covered? Should have a committee to decide. Rx's should be covered if effective and least expensive. I am not clear on once the final report is done where is it submitted and what is done after?

Response A: It is submitted to the governor/legislature. Will have the opportunity to present to policy makers. Some things we can move forward with now. Expanding Medicaid and reinsurance will both take more time and funds.

15. Long-term care not mentioned at all. Hope you address the institutional bias in Nebraska. Nursing homes, hospitals, and long-term care facilities these types of care are more expensive than home care. It would decrease Medicaid costs if services in the home were covered.

    Response A: Not really an uninsurance issue, but could be a possible strategy to reduce Medicaid costs.

16. I am responding to what happens next. The answer is in this room. We are working to fight cuts right now and we are all frustrated with the dilemma of our clients. This should be a solid wish list. What are the priorities you want the State of Nebraska to do?

17. We have asked the state Medicaid group to look at their requirements. Medicaid is the only one that will not look at LMHP diagnosis. Patients must be diagnosed and evaluated by a psychiatrist whenever there is a change in care even if their LMHP stays the same. A lot of wasted money with Medicaid because of requirements.

18. The future of the report is simple—getting all the votes. The people who are not here need to hear the strategies and communicate them to the legislature. I want to commend the Coalition for its work. Strategies 1 & 2 have the most potential. A question about premium assistance, how much would it cost in state dollars?

    Response A: Oklahoma just passed a premium assistance program that was about $50 million. If we just "nip" around the edges a few million would help, but not significantly. New York reinsurance threshold level is $5,000. Kansas is doing extensive reinsurance program. We should learn from them—they are paying several hundred thousand for the study. All depends on who is eligible. How do we avoid crowd out—public overtaking private? Probably would cost several million dollars.

19. Medicaid should establish state preferred drug list to get the best price in order to negotiate. Competing drugs could lower prices. Wyoming is saving money with the list. Medicaid authorization of entire therapeutic class is out dated.

20. What is the status of purchasing pool?

21. Private Strategy 3 (education) needs to be done for everyone. Everyone who goes to the doctor and just follows what they say. They could be taking something cheaper. We all need to be educated about how to best use health insurance.

22. Ideas—Many times people cannot get off to go to the doctor for prenatal care. Modify family leave act to allow time off for this. Central pharmacy strategy—Medicaid needs to directly negotiate with pharmaceuticals. The same drugs for animals cost much less. Uninsurable have to make a lot of money to pay for the insurance. What if we can buy into Medicaid? There are small business grants, but they can't start business without insurance at an affordable rate. This affects the economy. Instead of assisted living do congregate living communities. Residents can still own their own property and still have assets. Private and public need to work together.

23. Solutions need to be comprehensive enough to carry throughout the continuum, not just CHCs. United Health Care does a lot with disease management. We need a cost-effective disease management program.

24. There is a big gap between CHIP and Medicaid. Two grants have been received from the federal government to increase access and make more affordable, but this is not happening. Risk in premiums were increased and 10% of enrollment was lost. It is funded through the state and losses

covered through premium taxes. Need low income subsides to help people afford insurance. Access to CHIP is a safety net. Currently uninsured are being squeezed out of the individual market. Insurance companies sell different policies and stop marketing programs—healthy people drop out and we are left with sicker and sicker populations causing the premiums to go way up. There is a six-month waiting period for people to get on CHIP. Some individuals continue to pay normal high premiums and pay CHIP at the same time. This has not been addressed in the strategies.

25. Approach reinsurance—small business owners have dropped policies or have never tried. You read every day about rate increases. It is the one person causing the high rates. Reinsurance is a terrific idea—offers affordable insurance for the rest of the employees. It is potentially dangerous for the employers of the small business to make the commitment to provide insurance and then rates increase. Educational programs—many programs out there that people do not know about. California—persons actually qualified for programs but did not know about them. Also need to streamline accessing these programs. A lot of attitudinal barriers.

26. There is a lot of low hanging fruit. The Coalition should do what they can. Do the cheap ones. Include Douglas county programs in safety net. Should be able to have access for everyone. Marketing and outreach can be done without a lot of money. Expand drug discount, do special pharmacy and education strategies. In the long-term look at more expensive strategies. I encourage the coalition to go forward with ideas.

27. The guiding principle to add is accountability. What we are talking about is changing systems. We need to be monitoring and evaluating. We need to measure any intended differences (measurable outcomes to track progress). Bring evidenced-based practice. We need talk that leads to action.

28. Provider offices need education that Kids Connection is insurance for children. Need more outreach. More can be done and agree with accountability and evaluation.

29. A policy with a restrictive rider or with an extremely high deductible ($10,000) you might as well be uninsured. Becoming catastrophic coverage--some people live day to day to hope they do not have a catastrophic event happen.

Nebraska Health Insurance Policy Coalition
Lincoln Town Hall Meeting
May 10, 2005

Comments from the Audience

1. Cost to small employers is a concern. If employers might have to pay more, how will this affect economic development?

   What about agriculture/farmers? Could they get into a group and get lower rates? Even if it's only for catastrophic coverage.

   Dave—Most strategies we've proposed will not increase costs to small employers.
   Purchasing pools have not been successful in other states so far, so we haven't included them in the proposed strategies.

2. Pre-existing conditions?
   Dave--CHIP does allow people with pre-existing conditions to purchase insurance, but the rates are about 135% of the normal rate. So, many people can't afford CHIP.

   Coverage when people lose their jobs?
   Dave--If we could expand Medicaid coverage, that might help. Or, if we had more CHCs or satellites. However, if a person's income is higher, they wouldn't qualify for public programs.

How to cover the 63% of workers who are employed and uninsured?
Dave—Premium assistance program and reinsurance are possibilities.

3. Underinsured? Also, how likely is it that people who are underinsured will become uninsured? Also, need more health insurance options, such as health savings accounts.

   Dave—Premium assistance program would reduce costs to employer and employees. Reinsurance could also help here.

   Question: Any estimates of how many people are uninsured?

   Dave—Information gathered from Keith's household survey. The number is probably a little less than the number of uninsured in Nebraska.

4. Recommendations made here are just Bandaids! How about a long-term solution? There is nothing here about why health insurance is so expensive!

   Dave—Controlling health care costs is difficult. Premium costs to employers have gone up 55 to 60 percent. And, premiums rise faster and policies are less comprehensive for small employers or those who are self-employed. Ways that might help to control costs include better care coordination, disease management, timely use of preventive services. Ten percent of the population accounts for 70 percent of health care costs. The coalition has not addressed rising health care costs in detail—beyond scope of the grant.

5. Rise in number of Hispanic uninsured, including undocumented workers?

   Dave—undocumented workers are not eligible for Medicaid coverage.
   Andrea—CHCs do serve undocumented workers.
   Dave—CHCs can't reach all, but it would be helpful if we were able to get more CHCs, satellites, and look-alikes.

6. Ideas for small employers or farmers to have contract for care with CHC?

   Dave—CHCs would no doubt be willing to do this, but there are capacity issues.

   Income guidelines for COBRA assistance when job loss.

   Disease management with federal funds. Does it cover mental health?
   Dave—Could be covered but don't know to what extent.

7. Affordability of health insurance for employers and employees.

   We think that since increasing Medicaid costs, private reinsurance or pooling would be better than Medicaid sharing cost of premiums.

   A lot of retirees are being dropped from company health insurance—so, why not purchasing pools? Would reinsurance be available for employers or just insurers?

   Dave—Reinsurance: There are probably a lot of different ways you could do reinsurance. Being done successfully in 5+ states (NY, AZ, etc.)

8. Providers perspective—need to look at underlying causes of current problem.

   Bruce Dart: Cost—social injustice—government over-regulation becomes a cycle.
   Dave—Tradeoffs have to be made. Question is how to divide up costs, responsibilities, etc.

9. We liked some of the proposals: cost sharing with Medicaid, employer, and employee; reinsurance; behavioral (disease management?) But, where's the money going to come from?

   Cost containment—no easy answers. The strategies are good, but won't take care of the whole problem. Like the pharmacy strategies.

   Dave—Where the dollars could come from? There are a lot of costs to being uninsured, such as poorer child development from lack of affordable care, lost productivity due to illness/poor health. Things like this provide additional reasons for expanding programs.

10. Access to care is important, not just being insured. Lots of issues re access to care: transportation, lack of provider buy-in, maldistribution of health care providers, restrictions on scope of practice, undocumented workers/families needs, a 19% decrease in businesses offering health insurance.

11. Are we trying to find solutions? Can't just look at what we can afford. Health care is a right—not a privilege! People of color, rural people are in need. Need a vision. If we don't adopt one, we won't do anything about it.

    Andrea—This report/recommendations will go to the legislature for action. Coalition does have a vision but went for steps we thought were achievable.

12. Need to look at what outcome should be. A lot of the strategies involve Medicaid expansion, but we're looking at decreases in Medicaid federal funding. Also, likely the State may cut Medicaid. Don't think we can rely on Medicaid!

    Long-term care (insurance?) not addressed.
    Specialized (specialty?) care at CHCs—needs to be available.
    NE needs to talk about inclusive care—mental health, long-term care as well.

    Dave – Didn't have time for Coalition to look at how entire system should work. Our focus was strategies to decrease the number of uninsured and strengthen the safety net.

13. What strategy would give us the biggest decrease in number of insured (including minorities)?

    Dave--Expanding Medicaid would help Hispanics, because many work for small employers and have low wages. Reinsurance and premium assistance would also help those with jobs. These strategies have the most potential, but are also the most costly.

14. Do we have enough resources to provide care if everybody were to be insured, e.g., primary care in rural communities?

    Dave—Our supply would probably be adequate because these things won't happen all at once. Physicians might be in better supply than some other health professionals in some areas.

15. Why must health insurance be linked to employment? We need to have universal coverage. It's a right!

Other Comments:

- Your Guiding Principles state the strategies must be affordable to employers, employees, and government. Can't do that and have a good health care system.

  Dave—Tradeoffs are needed. We tried to make the strategies somewhat realistic so they wouldn't just be dismissed as not do-able.

- (From a representative of a small employer) We try to educate our employees to be better health care consumers. For example, we encourage them to shop for a provider, use Ask-A-Nurse, etc.

  Dave—Yes, that could be part of our educational efforts. It's also consistent with the disease management process.

- Are we asking the right questions here? Shouldn't we be asking, "What can we as a community do to keep people healthy?"

- We don't have a national health policy or a state one, so we have fragmentation and waste in the health care system.

Nebraska Health Insurance Policy Coalition
Norfolk Town Hall Meeting
May 11, 2005

Comments from the Audience

1. I have some concerns about the education program strategy– it seems like a new "jobs program" for state government. It seems like it would be very expensive and who is going to pay for it?

2. Does strategy #5 include Mental Health? It must if you are to be successful. I support the disease management concept – but we must reward providers and provide incentives to them to make it work. That must be included in your strategies.

3. Regarding the 340B Program – what are the 70 sites in Nebraska that can currently take advantage of the program? Are they Title 10 Programs, etc? What types of other providers would you target to expand the use of the 340 program?

4. Does the Coalition have any thoughts on how we can assist our current safety net providers, such as community health centers, critical access hospitals and rural health clinics to deal with the issue of the uninsured instead of creating new programs and facilities? How would it work?

5. What would role of the new safety net commission be? Also, it would be very helpful for the state to provide some start up funding for communities to work on FQHC application.

6. Could Nebraska apply for a demonstration project to move CHC services to existing rural hospitals and RHC?

7. What about local law enforcement dealing with inmates? Could these new CHCs work with local law enforcement to treat inmates in emergency protective services?

8. Did the coalition address any specific strategies to deal with undocumented people or refugees? How do the strategies presented address this group?

9. We need to find a better solution for those in the Kid's Connection Program who have dual coverage. Can't we find a way to couple Kids Connection and a private insurance subsidy without penalizing them for trying to purchase their own insurance.

10. I don't think expanding Medicaid is realistic. The funds at the state and federal level are just not there. The Coalition should look at other strategies.

11. Until we have a comprehensive federal and state health policy we are just plugging holes without fixing the problem.

12. Where is the healthy community concept in these strategies? Are we really addressing the core issue of improving health status?

13. I support the multi-state pharmaceutical purchasing program only if it includes local pharmacies.

Nebraska Health Insurance Policy Coalition
Grand Island Town Hall Meeting
May 24, 2005

Comments from the Audience

1. I would recommend that the Coalition, in future studies, look at insurance issues in the population over the age of 65. Also, the strategies need to address LTC insurance if you are going to have any impact on Medicaid savings in the future.

2. The Coalition needs to look at the issue of developing some kind of system to ease people off public assistance to work without the person losing more insurance coverage with a new employer than they have with Medicaid.

3. Did the committee look at immigrant eligibility under Medicaid? Can any changes be made?

4. Are these strategies really going to help? Is it time to look again at universal health care coverage?

5. How can the state assist the area of Grand Island with developing a FQHC? We have a very reluctant medical community, which is a barrier to making an application but the need is great here. (Note: The Nebraska Medical Association now has a task force to talk to communities with reluctant medical community regarding FQHCs.)

6. Does this plan do anything to address the shortage of health care professionals to take care of these additional uninsured people, especially in the rural areas of our state? Dental services are almost not existent for Medicaid patient let alone the uninsured.

7. Is the expansion of Medicaid even realistic? Given the number of medical providers who are not taking additional patients it seems like an unworkable strategy. Even if you move ahead with this strategy, if you don't address provider payment issues you will not be successful.

8. Did the Coalition have any discussion on increasing payments to providers under Medicaid? Were there any specific strategies to address the 18-25 age group and their unwillingness to obtain health insurance coverage?

9. Are the private recommendations for sharing insurance premiums realistic given the additional burden on the employer? What incentives would there be? Would you target only those employers who are not now providing insurance?

10. The Coalition should incorporate into their strategies the Pharmacy Plus Legislation that Nancy Thompson introduced this year for the uninsured to be able to purchase drugs at Medicaid price. Also, they should look at the preferred drug list legislation that was introduced.

11. I have a question about the Premium Assistance Program – isn't this a subsidy of the insurance industry? Why would we as taxpayers want to do that? How would it be financed?

12. Will the Coalition put any dollar figures to all the recommended strategies prior to making their final recommendations? It would be nice to see just how much money some of these things cost.

13. Any strategies need to look at prevention alternatives in an effort to lower health care costs.

Nebraska Health Insurance Policy Coalition
North Platte Town Hall Meeting
May 25, 2005

Comments from the Audience

1. Where does long term care insurance fit into these recommendations? Why aren't insurance purchasing pools included in the recommendations?

2. What can be done to improve access to dental services in rural Nebraska in your recommendations? Can a satellite clinic be set up from a FQHC to address this severe need in rural Nebraska?

3. A big issue in rural Nebraska for Medicaid and the uninsured is transportation to providers. Did the committee look at this issue?

4. The strategies don't include state tax incentives to help small employers provide insurance coverage? Why not?

5. Did the Coalition address how many people choose not to carry health insurance? What strategies are targeted at that group of people?

6. How can we solve this problem without addressing rising insurance and health care costs first?

Nebraska Health Insurance Policy Coalition
Scottsbluff/Gering Town Hall Meeting
May 26, 2005

Comments from the Audience

1. In rural areas, you must address the shortage of health professionals– are there enough health professionals in rural Nebraska to take care of all the uninsured?

2. Transportation to services is an issue in rural areas for the uninsured and Medicaid population.

3. I question the value of the data you obtained through the telephone survey. Does it really capture the true picture because most uninsured would not have telephones?

4. Why couldn't the state change the resource cap for Kids Connection? Let people spend down for provisions of medical care and it could be expanded to others in need.

5. I am very supportive of disease management recommendations. They must include mental health and incentive for providers to participate.

6. I think I am supportive of drug pooling provisions – but how would it work? Would local pharmacies be included?

7. I just have a comment. The Panhandle is currently doing some education with the uninsured, small businesses and insurance agents on the benefits of having health insurance. In August we are targeting some of our educational efforts towards students.

8. I am very supportive of the re-insurance concept. It should be targeted toward small farmers and ranchers who can no longer afford health insurance coverage.

9. Unless we address health care costs, I have serious reservations on how effective these recommendations will be.

10. With any of these proposals, I would recommend targeting small businesses that hire Medicaid (work first) so that people aren't afraid to lose their insurance.

11. I think the State of Nebraska should make a push at the federal level to expand the 340B benefits to critical access hospitals and rural health clinics.

12. We have a great system in place and I would recommend that the public health outreach nurses should be used with the disease management concept.